

Name : (Mr,Mrs,Miss) _____

Date: _____

Date of Birth: _____

Medical History:

Family Physician: _____

List all Eye medications and dosages you use _____

List all medications and dosages you use **OTHER THAN EYE MEDICATIONS:** _____

Are you allergic to any medications? _____

If so what was your allergic reaction? _____

Have you had any of the following:

Explanation of Problem

Previous Major Surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Heart Problems/Pacemaker	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
High Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Breathing Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Bowel Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Ulcers	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Kidney Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Stroke	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Seizures or Fainting	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Arthritis	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Thyroid Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Bleeding Tendencies	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Other Major Illness	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Keloid Scarring	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Seasonal Allergies	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Problems with anesthesia	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Autoimmune Diseases	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Claustrophobia/panic attacks	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____

Social History:

Do you smoke: yes no How Much? _____

Do you use alcohol: yes no How Much? _____

Your Occupation: _____

Your Hobbies: _____

(OVER)

EYE HISTORY

Approximate date of your last eye examination _____

What did the doctor say about your eyes? _____

Have you had any of the following?

			Explanation of Problem
Serious Eye Injuries/infections	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Eye Surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Glaucoma	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Cataracts	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Macular Degeneration	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Retina Detachment	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Crossed Eyes or Lazy Eye	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Dry Eye	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Contact Lenses	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Other Eye Diseases	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____

FAMILY HISTORY

Have any close blood relatives had any of the following problems?

			Which Relative?
Glaucoma	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Macular Degeneration	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Retina Detachment	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Cataracts	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Corneal Transplant	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Blindness	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Night Blindness	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Crossed Eyes	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
Heart Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____
High Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____